RI Department of Health

Application
and instructions for

Hospice Provider
RI General Laws Chapter 23-17-10

Licensee Name: _____

Licensee Number: _____

Reason for application (Please check all that apply):

1. ☐ Initial Licensure
2. ☐ Change of ownership
3. ☐ Change of address
4. ☐ Licensee/Residence Name Change

(Complete the following for either 1, 2, or 3)

Current residence name:_____ License #:_____

Current address:_____

5. ☐ Increase, or
6. ☐ Decrease in occupancy/bed capacity:

From:_____ To:_____

State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ballpoint pen.
- The fee for this license application is $3,000. A non-profit Hospice with a current Home Nursing Care Provider License is exempt from this fee.
- Sign the completed application and return to:
  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097.
- If you have any questions concerning this application, call the office of **Facilities Regulations** at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

You must attach a current printed list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.

Attachments: If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the following:

Federal Provider Number: (Leave blank if N/A)	Federal Provider Number: _____
Inpatient Facility	Is this program providing Hospice inpatient Care? YES ☐ NO ☐ If Yes, please note the inpatient bed capacity. ☐
License Sub-Type: Please select one	☐ Profit ☐ Non-Profit
Home Nursing Care License	☐ No ☐ Yes, License # _____ If Yes and you are Non-Profit, there is no License fee

Medical Director Information: Please provide the name of the Medical Director for this program. **NOTE: This section must be completed as a requirement of your license renewal.**	Name: _____ License Number: _____
Program Name: Please provide the name of the facility (as known to the public).	Name: _____
Program Administrator: Please provide the name and telephone number of the person we can contact concerning this facility.	Name: _____ Phone Number: ( ) _____
Program Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: _____ Phone Number: ( ) _____
Program Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____

Program Location Information: Please provide the location information for this facility. (**Published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Branch Office Information:	**Hospice Providers operating under a single license may establish branch offices under that same single license. To establish a branch office, you must provide all of the information requested. If you have more than one branch office, please copy this section as needed and attach to this application.** Branch Contact Name: _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address Line 4 _____ Phone Number: _____
Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Partner
Ownership Information: (Licensee) Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ (License Holder) DBA: _____

Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control	Corporation Type _____ Name of Organization _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Phone: _____ Fax: _____ Email Address: _____
Land/Building Info: If the owner of the land and building is other than the operator of this agency/facility, please complete the following:	Name: _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Phone _____
Services Provided: Please check which services are provided by your employees or through written agreement with others.	By Employees / Per Agreement / Not Provided Physician Services: ☐ ☐ ☐ Nursing Services: ☐ ☐ ☐ Physical Therapy: ☐ ☐ ☐ Occupational Therapy: ☐ ☐ ☐ Speech Therapy: ☐ ☐ ☐ Hearing Therapy: ☐ ☐ ☐ Social Services: ☐ ☐ ☐ Home Health Aide: ☐ ☐ ☐ Bereavement Services: ☐ ☐ ☐ Counseling Services: ☐ ☐ ☐ Volunteer Services: ☐ ☐ ☐ Other: List Additional Services _____ _____ _____

Acknowledgements

I am aware of Chapter 23-17-10 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17-10 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number: **(Federal Employer Identification Number)** **Note: If you are a sole proprietor this number may be your Social Security Number.**	**Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.** Please provide below SSN/FEIN for this license: SSN/F.E.I.N. Number: _____

Affidavit of Applicant

Read, sign, and date this affidavit.

AFFIDAVIT AND SIGNATURE

This Application Must be Signed

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

_____ _____

Signature of Authorized Person **Date of Signature (MM/DD/YY)**

_____

Printed Name of Authorized Person

_____

Title of Authorized Person

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.